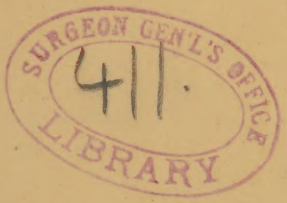
DALTON (H.C.)

Rupture of liver and Kidney – Excessive haemorrhage – Laparotomy – Recovery.



Reprint from WEEKLY MEDICAL REVIEW.

RUPTURE OF LIVER AND KIDNEY.—EXCESSIVE HÆMORRHAGE.—LAPAROTOMY.—RECOVERY.

BY H. C. DALTON, M.D.,

Superintendent City Hospital, St. Louis.

Chas. F., colored, æt. 28 years, hod carrier, a robust mulatto, was admitted to the City Hospital at 2:15 P.M., July 17, 1890. An hour before admission, while engaged in carrying brick to the top of a building, he lost his balance and fell from the fifth to the third story, a distance of about 25 feet, falling across an iron bar.

The bar struck him over the right lumbar region. Fortunately he caught the bar with both hands, and, although knocked almost senseless, held on until rescued by his fellow workmen.

Great nausea and faintness developed, but he neither vomited nor lost consciousness. When admitted to the hospital an hour after the injury his temperature (rectal) was 100°F., pulse 84 and regular, respiration 38.

Pressure gave considerable pain over the right lumbar and hypochondriac regions. There was no abrasion or contusion at the site of the injury. The urine was

drawn and found quite bloody. Percussion gave dull ness over the right lumbar region as high up as the axillary line. I considered the dullness due to the hæmorrhage, but did not know whether the blood came from the kidney or from the intra-peritoneal viscera.

As there was hæmaturia I thought its source was most likely renal. The patient's general condition was so good that I did not deem an operation advisable. He was given a dose of morphine and an ice bag was applied to the right lumbar region.

At 10 A.M., the next day, 19½ hours after the injury, his temperature (rectal) was 102.2, pulse 110, respiration 48. He had suffered considerable pain during the night, was very thirsty, and suffered considerably from nausea, though he did not vomit.

The abdomen was greatly distended and tender to pressure. Percussion elicited dullness (flatness) over both sides of the abdomen, extending well up towards the median line. The hæmaturia continued.

Believing that the hæmorrhage was due to a ruptured liver, I proceeded to perform laparotomy. After thorough antiseptic precautions were taken an incision was made eight inches long in the median line. When the first nick was made in the peritoneum a small stream of blood shot upward to a height of twelve or fourteen inches, due to the great intra abdominal tension. The cavity was full of fluid blood, except in the right dorsal gutter

and underneath the liver. At this point was found about a pint of dark, clotted blood.

The belly was thoroughly washed out. To do this I introduced the hard rubber nozzle of a hose throwing a ¾ inch stream, connected to a large reservoir placed 10 feet above the level of the patient.

Passing my hand underneath the liver near its outer portion I discovered a large rent about three inches in length, into which I could place my index finger. Considerable blood was oozing from this wound.

As it was impossible to reach and close it by suture I resorted to the gauze tamponade. A double-handful of gauze was packed around the wound, the end of each strip left protruding from the upper angle of the parietal wound. The belly was closed by interrupted silk sutures involving skin, muscles, and peritoneum. Pelvic drainage was not used.

A remarkable feature of the case was that temperature, pulse and respiration improved during the operation. As stated above, immediately before the operation the temperature (rectal) was 102.2, pulse 110, respiration 48. Immediately after the operation, as soon as the patient was put to bed, the temperature (rectal) was 101.2, pulse 100, respiration 22.

So that *during the operation* the temperature fell a degree, the pulse fell from 110 to 100, and the respiration fell from 48 to 22.

The improvement continued, the temperature never going above 100 5 after the operation. The gauze was removed on the second day. Hæmorrhage did not follow its withdrawal. The hæmaturia ceased in two or three days, and the patient was discharged well August 23, 1890.

In looking back at this case I see where I could have done better in one particular. That is, instead of having the ends of the strips of gauze protruding from the upper angle of the median incision I should have made an opening in the lumbar region for this purpose.

Then, should hæmorrhage have taken place, the fluid would not have had to overcome gravity, and the peritoneal cavity around this region would have been well drained.

It has been my experience, and I presume it has been noticed by others (although I have not seen the statement made), that negroes stand injuries and surgical interference far better than the white race. As a rule this does not hold good in the mulatto.

On the other hand, the negro does not compete with his white brother in withstanding diseased conditions other than surgical.